The role of diaspora in building resilient health systems in fragile settings: key findings and policy recommendations

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Background

Health systems in fragile and shock-prone settings (FASPs) face intersecting and recurrent crises, including conflict, climate-related disasters, and economic instability, which severely disrupt service delivery and system functioning. These settings are also characterised by substantial diaspora populations, driven by both voluntary and forced migration. Lebanon, for example, has a diaspora population estimated to be three times larger than the population remaining in-country. Diaspora have emerged as key actors in supporting both community survival and the functioning of health systems during crises [1]. However, there is limited evidence on how diaspora contributions shape health system resilience in FASPs. This brief draws on a multi-country study by ReBUILD for Resilience, examining diaspora engagement and contributions to health system resilience across global literature and five case study countries: Sudan, Sierra Leone, Lebanon, Myanmar, and Nepal.

Main findings

How do diaspora contribute to the resilience of health systems in fragile and shock-prone settings?

Diaspora draw on **financial, human, and social capital** to support multiple dimensions of health system resilience across FASPs (Figure 1). While these contributions are broadly consistent across contexts, the nature and scale of these contributions are shaped by the country context, with acute crises - particularly conflict and natural disasters - triggering rapid mobilisation of financial resources for emergency response.

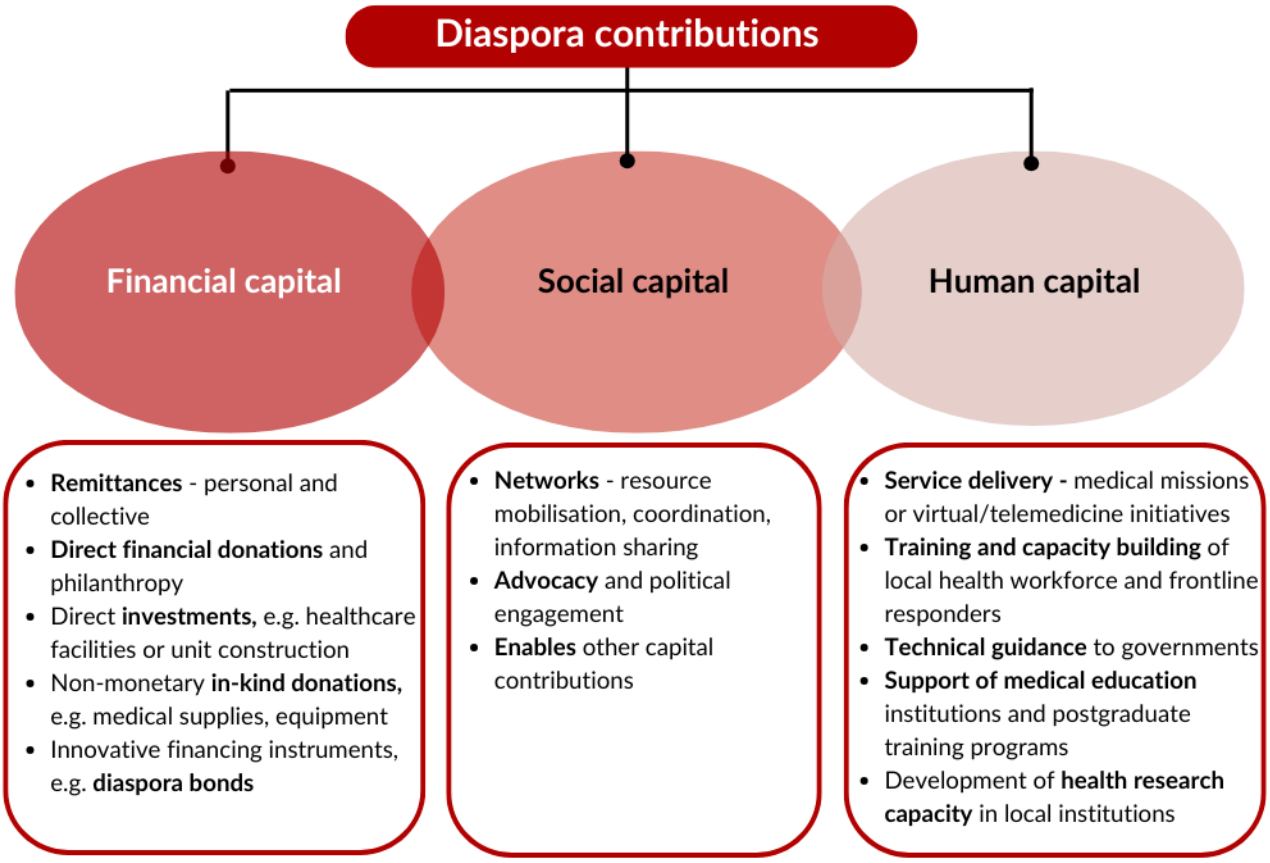

Figure 1: Diaspora contributions to health systems and communities in FASPs

Financial capital

Across all case studies, financial capital is the most immediate and prominent form of diaspora contribution. Remittances function as **critical lifelines for households,** financing access to basic services, including healthcare, thereby indirectly sustaining health systems. In Lebanon, remittances reached an estimated US$7–8 billion annually (around one-third of GDP), and are similarly substantial across Sudan, Sierra Leone, Nepal, and other FASPs.

Beyond household transfers, diaspora mobilise **substantial financial donations,** particularly during crises. Across Myanmar, Sudan, and Lebanon, diaspora organise global fundraising initiatives and leverage transnational networks to rapidly fund medicines, emergency response, and community-based support.

In several settings, these financial and in-kind contributions extend to **direct health system** inputs, including financing hospital reconstruction (Sudan), supporting facility operations (Sierra Leone, Lebanon), and providing in-kind supplies such as medicines and PPE during COVID-19 and periods of drug shortages (Lebanon, Sudan).

Human capital

Diaspora human capital plays a critical role in **maintaining service delivery** during acute disruption and strengthening system capacity for adaptation. Across FASPs, diaspora health professionals support service delivery through short-term missions and remote modalities, including telemedicine, enabling continuity of basic and specialised care, particularly in conflict settings.

Another major contribution is **training and capacity building** of the local health workforce and frontline responders in crisis, alongside longer-term contributions to medical education and postgraduate training. For example, in Sudan, large-scale virtual training programmes reached thousands of frontline workers during the war.

Diaspora also contribute to **system-level functions,** including technical guidance, policy input, and governance support through participation in national taskforces and strategic processes. However, these contributions are often episodic and reliant on individual or network-driven initiatives, with limited institutional integration into national health systems.

Social capital

Social capital is foundational to how diaspora contributions are mobilised and delivered, operating through **dense, trust-based networks** that connect actors across global, national and local levels.

These networks, spanning **family, community and professional channels,** facilitate mobilisation of resources, coordination, flow of information, and are central to enabling engagement. Diaspora often rely on trusted contacts within ministries or local systems to channel support rapidly during crises.

In addition, particularly in conflict-affected FASPs such as Myanmar and Sudan, diaspora engage in **advocacy and political mobilisation,** raising awareness and mobilising international support during crises.

Outcomes and effects on the resilience of health systems

Diaspora contributions most **strongly support absorptive capacity,** enabling continuity of services and crisis response. They also **contribute to adaptive capacity** through knowledge exchange, skills transfer, and innovation. **Transformative effects remain limited** across contexts and are highly contingent on health system structures and the capacity to effectively govern and integrate diaspora engagement.

At the same time, **diaspora contributions can generate unintended effects,** including misalignment with local needs, increased fragmentation, and reinforcement of existing system challenges, such as health worker emigration and inequities in access. Their largely informal, crisis-driven nature also raises concerns around sustainability.

How do diaspora engage and what factors affect engagement?

Diaspora engagement operates through multiple, overlapping channels, spanning informal, professional, organisational, and government-led mechanisms. The most pervasive forms are **personal and informal networks,** particularly family- and community-based ties, through which remittances and in-kind support are channelled directly to households and local actors, as seen in Lebanon, Myanmar, and Nepal. In Lebanon, sectarian channels shape engagement patterns.

These are complemented by **professional networks,** including diaspora medical associations and institutional collaborations, which facilitate training, service delivery, and technical exchange across contexts such as Myanmar, Sudan, Sierra Leone, and Nepal.

Diaspora also engage through a range of **organisational platforms,** from grassroots groups and diaspora associations to NGOs and international coalitions, which play a central role in mobilising resources and coordinating responses during crises across all FASPs.

Alongside these, more formal **government-led mechanisms** exist in some contexts, including diaspora offices within ministries or dedicated state institutions (e.g. Sudan, Sierra Leone, Nepal and Lebanon), whereas broader evidence suggests that only around half of fragile settings have formal institutional arrangements for diaspora engagement. However, even when present, these mechanisms remain limited in operationalisation and effectiveness.

Overall, diaspora engagement remains predominantly informal, network-driven, and crisis-responsive, resulting in hybrid systems where informal and formal channels coexist but are weakly coordinated. Across all countries, a set of common factors shapes the scale and impact of diaspora engagement, summarised in Figure 2.

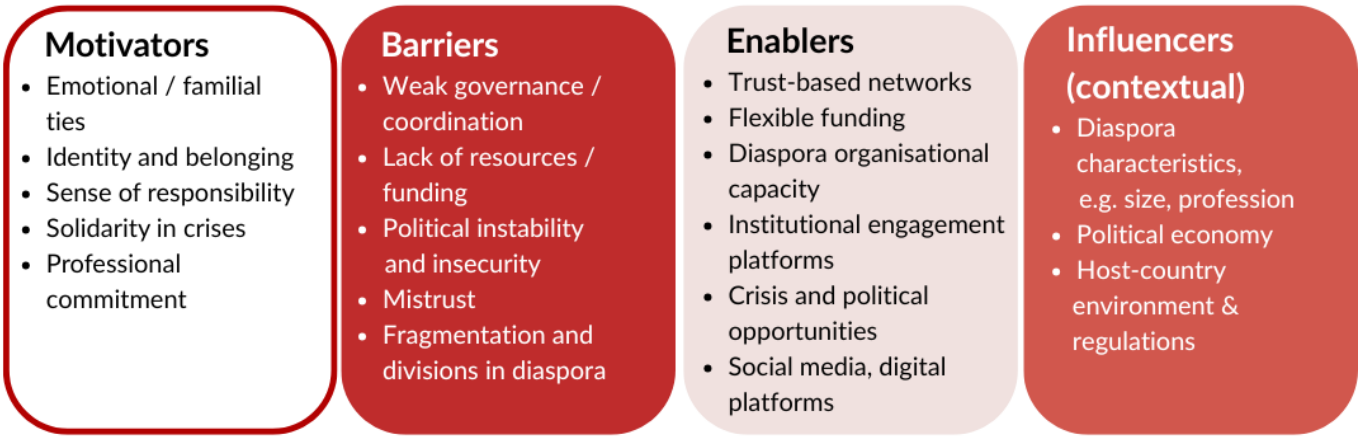

Figure 2: Factors shaping diaspora engagement for resilient health systems in FASPs

Key policy messages

Recognise diaspora as essential partners in building resilient health systems. Their combined financial, human, and social capital represent a critical resilience capability in FASPs. However, the impact and sustainability of these contributions depend on the capacity of health systems to effectively govern, channel, and absorb them at national and local levels.

Shift from ad-hoc crisis-driven engagement to strategic, system-level integration. Diaspora, governments and partners should establish or strengthen facilitative governance mechanisms that can map, coordinate, and align diaspora contributions with health system priorities. These mechanisms must be flexible by design, recognising the central role of informal, trust-based networks, while improving coordination with formal structures without undermining diaspora autonomy. Specific actions include identifying:

- "who" through mapping diaspora, their capacities and pathways of support,
- "what" through shared dialogue to co-produce national health priorities and diaspora roles, and
- "how" through transparent mechanisms for coordination and accountability.

Adopt a whole-of-government and multi-stakeholder approach. The health sector cannot act alone, and governments too cannot act alone. Effective diaspora engagement extends beyond the health sector and requires coordinated action across government, alongside engagement with local actors, diaspora organisations, and international partners. Governance mechanisms should reflect this plurality of actors and roles.

Prioritise trust-building as a foundation for effective partnerships. Strengthening dialogue, transparency, and accountability – and enabling co-production of priorities between diaspora and domestic actors – is essential to unlock sustained and meaningful engagement.

Tailor engagement to political and institutional realities. Diaspora engagement is shaped by diaspora–state relations and broader political economy dynamics. In contexts where trust in state institutions is limited, or state legitimacy is contested, engagement models must adapt accordingly, including mechanisms that are hybrid or non-state where appropriate.

Empower diaspora, reduce barriers and create enabling conditions through supportive policies, increased funding, and clear entry points, all of which are essential for sustained engagement.

Methodological notes

This brief draws from a multi-country research study conducted in Sierra Leone, Lebanon, Myanmar, and Nepal. The study comprised:

- a global strand that included a scoping review of global literature [2] and key informant interviews with international experts, informants from diaspora, multilateral agencies such as IOM and WHO, and multinational technology companies, e.g. Meta, and
- country case studies including document reviews and key informant interviews with government officials, diaspora representatives, health facility managers, community organisations, and academics or experts.

Bibliography

1. Dafallah, A and Witter, S (2025) Diaspora as Partners: Strengthening Resilience of Health Systems and Communities Amidst Aid Volatility. *BMJ Global Health*, 10:e019622
2. Dafallah, A, Kamara, H, Gautam, G, Witter, S (2025) The role of diaspora in strengthening health system resilience in fragile and shock-prone settings: A scoping review. Submitted to *Social Science and Medicine*, *Health Systems* (special edition). *(Forthcoming)*
3. Dafallah, A et al. (2026) What can we learn about the role of diaspora in resilience of health systems in FASP settings? Comparative findings from Sudan, Sierra Leone, Lebanon, Myanmar and Nepal. *BMJ Glob Health. (Forthcoming).*

This brief is one of a series on diaspora produced by ReBUILD for Resilience. Find others and further information on this study - *the role of the diaspora in supporting health system resilience in fragile and shock-prone settings* – on the ReBUILD website.

https://www.rebuildconsortium.com/projects/diaspora-health-system-resilience/

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